excision and suture. The first is adapted to subjects so feeble that no operative procedure is justifiable; the second to well-nourished patients who bear the anæsthetic well; the third to intermediate cases.—*N. Y. Med. Jour.*, Mar 19, 1887.

JAMES E. PILCHER (U. S. Army).

X. Case of Herniotomy With Excision of Gangrenous Portion of Intestine. Recovery. RUSHTON PARKER, F. R. C. S. (Liverpool). In this case, which makes the third, in which the author during the last four years has performed excision of gut in herniotomy, the result was successful. The patient was admitted with strangulated inguino-scrotal hernia on the left side, of about 24 hours' duration. On opening the sac, excessively fœtid, blood-stained liquid escaped, revealing a coil of greenish-black small intestine, and a mass of omentum. The neck of the sac was the external abdominal ring tightly embracing the contents. On freely laying open the sac through the stricture, the peritoneal aperture was plugged with a sponge soaked in perchloride of mercury solution, while the unsound contents were being excised. The narrow omental pedicle was tied with catgut in two portions, cut beyond, and the stump returned, while the whole of the intestinal coil, steeped in and dripping with putrid liquid, was cut away with a corresponding wedge of mesentery, hæmorrhage being prevented or arrested by clamping with the fingers and by sponge pressure until the bleeding vessels were tied with catgut. The mesenteric gap was closed by continuous catgut suture, and the intestinal tube reunited by means of interrupted stitches of the same material.

These latter penetrated no deeper than the muscular layers, and were passed twice through the tissues of each piece of gut, so as to bring peritoneum close up to peritoneum, leaving the cut ends of the tube inverted into the canal. After the reduction of the loop of united gut the question of radical cure suggested itself, but here, owing to the laxity of the margins of the inguinal outlet, something more appeared to be necessary than the mere dealing with the sac. Consequently, examination of the testicle having shown it to be atrophied, it together with the tunica vaginalis and all the scrotal part of the hernial sac, injured by putrid imbi[illegible]on as the latter was—were stripped up to the level of

the inguinal canal, and the cord tied with separate ligatures on each artery, and one round the whole. The abdominal aperture was then closely sewed with catgut sutures as far down as the edge of the pubic bone. A drainage tube, stitches and Listerian dressings were then applied to the superficial part of the wound.

The patient passed the first week in a precarious state; but subsequently to this improvement set in and on the 20th day meat was allowed and he began to sit up for a short time daily. The deep parts of the wound within the sutures of the inguinal canal healed up by first intention, while the subcutaneous and cutaneous part gaped, and healed by granulation. Thirty-seven days after the operation the patient left for a convalescent hospital having a small sinus which has since gradually closed.—*Brit. Med. Jour.*, Jan. 22, 1887.

XI. **Case of Fæcal Impaction With Complete Obstruction; Relieved by Introduction of Hand After Full Division of Anus.** By PRICE MORRIS, L. R. C. P. The author gives the notes of the case of a young lady aged 24, who first came under his care some years ago complaining of symptoms of indigestion, occasional vomiting, and who on examination was found to have large, nodulated, firm, painless, movable tumors occupying the lower part, and chiefly left side of the abdominal cavity—and whose rectum was so distended from fecal accumulation that a child at full period could easily have passed through it. By diligent use of soaped warm water, and manual exercise, the mass was broken up and removed. For ten months the patient remained well. and at the end of that time she again came under the author's care suffering from the same symptoms. The treatment which was of so much service upon the former occasion failed to relieve altogether the obstruction. A mass was left in the sigmoid flexure of the colon which would not descend into the pelvis. Injections were of no avail, owing to the compactness of the mass. Treatment in this direction failing, symptoms of complete obstruction supervened, vomiting followed every meal; and no fecal discharge took place.

The patient subsequently became very emaciated, and death from starvation appeared to be within a measurable distance of time. The